Company Tracking Number: 08-AP-5-F

TOI: 17.0 Other Liability - Claims Made/Occurrence Sub-TOI: 17.0009 Employers Liability

Product Name: Employer Stop Loss
Project Name/Number: Arkansas Application /

Filing at a Glance

Company: Federal Insurance Company

Product Name: Employer Stop Loss SERFF Tr Num: CHUB-125723299 State: Arkansas

TOI: 17.0 Other Liability - Claims SERFF Status: Closed State Tr Num: #371729 \$20

Made/Occurrence

Sub-TOI: 17.0009 Employers Liability Co Tr Num: 08-AP-5-F State Status: Fees verified and

received

Filing Type: Form Co Status: Reviewer(s): Betty Montesi, Edith

Roberts

Authors: Diana Cardone, Susan Disposition Date: 07/15/2008

Leonard

Date Submitted: 07/08/2008 Disposition Status: Approved

Effective Date Requested (New): On Approval

Effective Date (New):

Effective Date Requested (Renewal): Effective Date (Renewal):

State Filing Description:

General Information

Project Name: Arkansas Application Status of Filing in Domicile: Not Filed

Project Number: Domicile Status Comments:

Reference Organization: Reference Number:
Reference Title: Advisory Org. Circular:

Filing Status Changed: 07/15/2008

State Status Changed: 07/15/2008

Corresponding Filing Tracking Number:

Filing Description:

RE Federal Insurance Company

NAIC: 038-20281 FICA: 13-1963496

Form #'s 14-03-0485 (7/2008) Application

Company Tracking Number: 08-AP-5-F

TOI: 17.0 Other Liability - Claims Made/Occurrence Sub-TOI: 17.0009 Employers Liability

Product Name: Employer Stop Loss
Project Name/Number: Arkansas Application /

In response to Bulletin 6-2008, we are adding the required notice to our stop loss application. This form was previousl filed and approved by you department. This is the only change being made to this form. Your approval will be greatly appreciated.

Your approval for policies issued under this program will be greatly appreciated.

Sincerely,

Chubb & Son

A division of Federal Insurance Company

By: Fran Muldoon

Fran Muldoon, AVPManager,

State Filings Department

Company and Contact

Filing Contact Information

Fran Muldoon, Manager - CPI State Filngs fmuldoon@chubb.com

Dept.

202 Hall's Mill Rd. (908) 572-2875 [Phone] Whitehouse Station, NJ 08889-9977 (908) 572-4034[FAX]

Filing Company Information

Federal Insurance Company CoCode: 20281 State of Domicile: Indiana

202 Hall's Mill Road Group Code: 38 Company Type:

P.O. Box 1650

Whitehouse Station, NJ 08889-1650 Group Name: State ID Number:

(908) 572-4726 ext. [Phone] FEIN Number: 13-1963496

Company Tracking Number: 08-AP-5-F

TOI: 17.0 Other Liability - Claims Made/Occurrence Sub-TOI: 17.0009 Employers Liability

Product Name: Employer Stop Loss
Project Name/Number: Arkansas Application /

Filing Fees

Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No

Fee Explanation: \$20.00 Fee to correct a previously filed form

Per Company: No

COMPANY AMOUNT DATE PROCESSED TRANSACTION #

Federal Insurance Company \$0.00 07/08/2008

CHECK NUMBER CHECK AMOUNT CHECK DATE 00371729 \$20.00 07/08/2008

Company Tracking Number: 08-AP-5-F

TOI: 17.0 Other Liability - Claims Made/Occurrence Sub-TOI: 17.0009 Employers Liability

Product Name: Employer Stop Loss
Project Name/Number: Arkansas Application /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Edith Roberts	07/15/2008	07/15/2008

SERFF Tracking Number: CHUB-125723299 State: Arkansas

Filing Company: Federal Insurance Company State Tracking Number: #371729 \$20

Company Tracking Number: 08-AP-5-F

TOI: 17.0 Other Liability - Claims Made/Occurrence Sub-TOI: 17.0009 Employers Liability

Product Name: Employer Stop Loss
Project Name/Number: Arkansas Application /

Disposition

Disposition Date: 07/15/2008

Effective Date (New):

Effective Date (Renewal):

Status: Approved

Comment:

Rate data does NOT apply to filing.

Company Tracking Number: 08-AP-5-F

TOI: 17.0 Other Liability - Claims Made/Occurrence Sub-TOI: 17.0009 Employers Liability

Product Name: Employer Stop Loss
Project Name/Number: Arkansas Application /

Item Type Item Name Item Status Public Access

Yes

Supporting Document Uniform Transmittal Document-Property & Approved

Casualty

Form Stop Loss Application Approved Yes

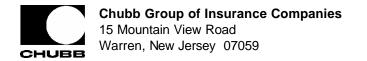
Company Tracking Number: 08-AP-5-F

TOI: 17.0 Other Liability - Claims Made/Occurrence Sub-TOI: 17.0009 Employers Liability

Product Name: Employer Stop Loss
Project Name/Number: Arkansas Application /

Form Schedule

Review	Form Name	Form #	Edition	Form Type Action	Action Specific Readability	Attachment
Status			Date		Data	
Approved	Stop Loss	14-03-	7/2008	Application/Replaced	Replaced Form #:	14-03-0485
	Application	0485		Binder/Enro	14-03-0485(Ed	EE Stop
				llment	3/2003)	Loss App
					Previous Filing #:	Rev 7
					03-AP-F	2008.pdf

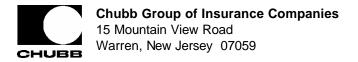


BY COMPLETING THIS APPLICATION YOU ARE APPLYING FOR COVERAGE WITH FEDERAL INSURANCE COMPANY (THE "COMPANY")

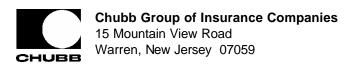
APPLICATION INSTRUCTIONS:

- 1. Whenever used in this Application, the term "Applicant" shall mean the insured and all subsidiaries.
- 2. Include all requested underwriting information and attachments. Provide a complete response to all questions and attach additional pages if necessary.

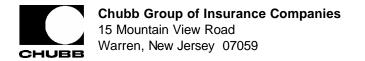
I.	GE	ENERAL INFORMATION			
	1.	Name of Applicant :			
	2.	Address of Applicant :			
		City: Sta	te: Zip Co	ode: T	elephone:
	3.	Web address:			
	4.	Name and Address of Prima	ry Contact:		
		City: Stat	e: Zip Co	de: T	elephone:
	5.	` '	☐ No d complete address of ar	ny/all including number	r of employees at each location.
	6.		I name, location(s), and r	number of employees	enefit plan? Yes No for each (companies under common
II.	SP 1.	ECIFIC INFORMATION: Enter the full name of your be must be attached.)	penefit plan(s): (A copy of	such executed benef	it plan(s), including all amendments,
	2.	Nature of Applicant's Prima Federal Employer's Tax I.D. Number of Years in Busines	#:		



	4.	Estimated Initial Enrollment:						
		Single/Employee only COBRA Beneficiaries						
		Employee and Spouse Retired Employees						
		Employee and Child(ren)						
		Family (Employee/Spouse/Children)						
	5.	Proposed Effective Date:						
	6.	Name and Address of Designated Third Party Administrator: (Firm)						
III.		Policy Period Requested: From the both days at 12,01 a.m. at the principal address of the incured						
		From to both days at 12:01 a.m. at the principal address of the insured.						
	2.	Covered Persons Included: a. Retired Employees: b. COBRA Beneficiaries c. Disabled Persons Covered Perso						
	3.	Actively At Work Provision						
		 □ Actively At Work Provision Applies □ Actively At Work Provision Waived (with Company approval and completed employer disclosure statement) 						
IV.	RE	QUESTED COVERAGE:						
A.	Sp	ecific Stop Loss Insurance Requested:						
	1.	Requested Under the Policy: ☐ Yes ☐ No						
	2.	Requested Services To Include: Medical Prescription Drug Prescription Drug Card Prescription Drug Card No						
	3.	Requested Services Incurred From:To:						
Specific Retention Amount Per Covered Person Per Policy Period: \$								



5.	Insured Percentage:%
6.	Paid by the Insured From:To
7.	Claim Reporting Deadline:
8.	Maximum Specific Benefit Per Covered Person: A. Per Policy Period: \$ B. Lifetime Maximum Per Covered Person: \$
9.	Specific Monthly Premium Rates: \$Per Single/Employee Only Covered Unit \$Per Employee and Spouse Covered Unit \$Per Employee and Child(ren) Covered Unit \$Per Family (Employee/Spouse/Children) Covered Unit
Ag	ggregate Stop Loss Insurance Requested:
1.	Requested Under the Policy: ☐ Yes ☐ No
2.	Requested Services to Include: Medical
3.	Requested Services Incurred From:To:
4.	Run-in Limit (if applicable): A. Covered services Incurred from: To: B. Not to exceed: \$
5.	Minimum Aggregate Retention Per Policy Period: \$
6.	Monthly Aggregate Factors: \$Per Single/Employee Only Covered Unit \$Per Employee and Spouse Covered Unit \$Per Employee and Child(ren) Covered Unit \$Per Family (Employee/Spouse/Children) Covered Unit
7.	Insured Percentage:%
8.	Paid by the Insured From: To:
9.	Claim Reporting Deadline:
10.	Maximum Aggregate Benefit Per Policy Period: \$
11.	. Aggregate Monthly Premium Rates:
	\$Per Single/Employee Only Covered Unit
	\$Per Employee and Spouse Covered Unit \$ Per Employee and Child(ren) Covered Unit

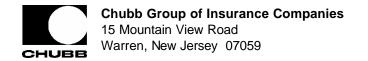


		\$Per Family (Employee	e/Spouse/Children) Covered Unit						
C.	Ad	Additional Options Requested:							
	1.	Monthly Aggregate Cap Option Requested:	□ Yes □ No						
	2.	Terminal Liability Option Requested:	□ Yes □ No						
	3. 4.	Specific Advance Option Requested: \$ Terminal Liability Risk Premiur	☐ Yes ☐ No m Per Employee						
	5.	Terminal Liability Attachment Factors: \$Per Single/Employee of the per Employee and Sp \$Per Employee and Ch \$Per Family (Employee)	ouse Covered Unit ild(ren) Covered Unit						
D.	No rea	Representation: Prior Knowledge of Facts/Circumstances/Situations: No person or entity proposed for coverage is aware of any fact, circumstance, or situation which he or she has reason to suppose might give rise to any claim that would fall within the scope of the proposed coverage, except: NONE or							
	an _y su	y such fact, circumstance, or situation exists,	es of the Company, the Applicant understands and agrees that if whether or not disclosed above, any claim or action arising from ded from the proposed coverage if a policy is issued by the						
٧.	MA	ATERIAL CHANGE:							
			testions in this Application before the policy inception date, the ting, and any outstanding quotation may be modified or withdrawn.						
VI.	NC	OTICES:							

Receipt of any money in connection with this Application shall not constitute an acceptance of liability. In the event the Company disapproves this Application, its sole obligation shall be to refund such sum to the **Applicant**.

The Applicant's submission of this Application does not obligate the Company to issue a policy. The **Applicant** will be advised if the Application for coverage is accepted. The **Applicant** authorizes the Company to make any inquiry in connection with this Application.

Notice to Arkansas, Louisiana, Maryland, Minnesota, New Mexico and Ohio Applicants: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false, fraudulent or deceptive statement is, or may be found to be, guilty of insurance fraud, which is a crime, and may be subject to civil fines and criminal penalties.



Notice to Colorado Applicants: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory agencies.

Notice to District of Columbia,

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant

Notice to Maine, Tennessee and Virginia Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Notice to Florida and Oklahoma Applicants: Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony (in Oklahoma) of the third degree (in Florida).

Notice to Kentucky Applicants: Any person who, knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to Oregon and Texas Applicants: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

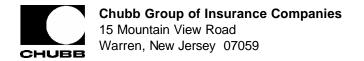
Notice to Pennsylvania and New York Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation (in New York) or criminal and civil penalties (in Pennsylvania).

Notice to Washington Applicants:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the Company. Penalties include imprisonment, fines and denial of insurance benefits.

VII. DECLARATION AND SIGNATURE:

For the purposes of this Application, the undersigned authorized agents of the person(s) and entity(ies) proposed for this insurance declare to the best of their knowledge and belief, after reasonable inquiry, the statements made in this Application and any attachments or information submitted with this Application, are true and complete. The undersigned agree that this Application and its attachments shall be the basis of a contract should a policy providing the requested coverage be issued and shall be deemed to be attached to and shall form a part of any such policy. The Company will have relied upon this Application, its attachments, and such other information submitted therewith in issuing the proposed coverage.



The information requested in this Application is for underwriting purposes only and does not constitute notice to the Company under any policy of a claim or potential claim.

Company under any polic	y of a claim or po	tential claim.		
		ef executive officer and chi and entity(ies) proposed f		er of the Insured acting as the e.
Date	Signature		Title	
		<u>C</u> I	nief Executive Of	<u>'ficer</u>
		<u>C</u> I	nief Financial Off	<u>icer</u>
purchase of stop loss cov funded health plan. Emplo policy and/or the provision the health plan. For instar	erage and/or exceptions and or exception spensors in the self-fundence, if medical class stop loss policy. I	ess loss coverage as comors should be aware that the ed health plan may cause tims are paid on an ineligited in addition, the Arkansas I	plete protection on the failure to come the employer/plance to individual, the	plans should not consider the from all liability created by the self- liply with the terms of the stop loss an sponsor to incur liabilities under a stop loss carrier may deny the insurance Guaranty Association
PRODUCED BY (Insurance	e Agent)		INSURANCE AC	BENCY
INSURANCE AGENCY TAX	(PAYER ID OR SOC	CIAL SECURITY NO.	AGENT LICENS	SE NO.
ADDRESS (No., Street, C	ity, State, and ZIP	Code)		
EMAIL ADDRESS				
SUBMITTED BY (Insura	ance Agency)	INSURANCE AGENCY OR SOCIAL SECURITY		AGENT LICENSE NO.
ADDRESS (No., Street,	City, State, and	ZIP Code)		1

SERFF Tracking Number: CHUB-125723299 State: Arkansas State Tracking Number: #371729 \$20

Filing Company: Federal Insurance Company

08-AP-5-F

TOI: 17.0 Other Liability - Claims Made/Occurrence Sub-TOI: 17.0009 Employers Liability

Product Name: Employer Stop Loss Project Name/Number: Arkansas Application /

Rate Information

Company Tracking Number:

Rate data does NOT apply to filing.

Company Tracking Number: 08-AP-5-F

TOI: 17.0 Other Liability - Claims Made/Occurrence Sub-TOI: 17.0009 Employers Liability

Product Name: Employer Stop Loss
Project Name/Number: Arkansas Application /

Supporting Document Schedules

Review Status:

Satisfied -Name: Uniform Transmittal Document- Approved 07/15/2008

Property & Casualty

Comments:

Please see attached

Attachment:

ARK NAIC trans 08 AP 05.pdf

Property & Casualty Transmittal Document

Reset Form

1.	Reserved for Insurance	2. Ins	uran	ice Deb	artment L	Jse only			
1.	Dept. Use Only		a. Date the filing is received:						
			b. Analyst:						
		c. Dis							
		1	ate of disposition of the filing:						
				e date o					
		0		ew Bus					
			Renewal Business						
		f. Sta							
		g. SE	RFF	Filing #					
		h. Su	oiect	Codes					
3.	Group Name						Group NAIC #		
	Chubb Group of Insurance Comp	oanies					038		
4.	Company Name(s)		Don	nicile	NAIC #	FEIN #	State #		
	Federal Insurance Company		INDI	ANA	20281	13-1963496			
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				I oo AD G					
5.	Company Tracking Number	•		08-AP-5	5F				
	Company Tracking Number) [inc	clude tol	l-free numb				
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Con	ntact Info of Filer(s) or Corporate Name and address Fran Muldoon	e Officer(s	!	clude tol	l-free numb hone #s	FAX#	e-mail fmuldoon@chubb.com		
Con	ntact Info of Filer(s) or Corporate Name and address Fran Muldoon 202 Hall's Mill Rd	e Officer(s	!	clude tol	l-free numb hone #s	FAX#			
Con 6.	Name and address Fran Muldoon 202 Hall's Mill Rd Whitehouse Station NJ 08889	e Officer(s	!	clude tol	l-free numb hone #s	FAX#			
6. 7.	Name and address Fran Muldoon 202 Hall's Mill Rd Whitehouse Station NJ 08889 Signature of authorized filer	e Officer(s Title Manage	!	clude tol Telep 9085	I-free numb shone #s 722875	FAX#			
7.	Name and address Fran Muldoon 202 Hall's Mill Rd Whitehouse Station NJ 08889 Signature of authorized filer Please print name of authoriz	e Officer(s Title Manage	r	Standard March 19085	I-free numb hone #s 722875	FAX# 908 5724034			
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Property & Casualty Transmittal Document—

 This filing transmittal is part of Company Tracking # 08-Ap-5 F Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text] This filing is to comply with the department bulletin regarding a notice to employers purchasing stop loss insurance. We have placed the required notice on the application. It is the only change we are making to the form.
This filing is to comply with the department bulletin regarding a notice to employers purchasing stop loss insurance. We have placed the required notice on the application. It is the only change we are making to
stop loss insurance. We have placed the required notice on the application. It is the only change we are making to
View Complete Filing Description
22. Filing Fees (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]
Check #: <u>56.3717.29</u> Amount: \$20.00
Refer to each state's checklist for additional state specific requirements or instructions on calculating fees. ***Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies

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required, other state specific forms, etc.)

FORM FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes forms) (Do <u>not</u> refer to the body of the filing for the forms listing, unless allowed by state.)

1	. This filing transmittal is part of Company Tracking # 08-AP-5 F								
2	This filing corresponds to rate/rule filing number (Company tracking number of rate/rule filing, if applicable)								
3	Form Name Form # Include edition date		Replacement Or withdrawn?	If replacement, give form # it replaces	Previous state filing number, if required by state				
0	ESL application	14-03-0485 (Ed 7/2008)	☐ New ☑ Replacement ☐ Withdrawn	14-03-0485 (Ed 3/2003)					
0	2		☐ New ☐ Replacement ☐ Withdrawn						
O	3		☐ New ☐ Replacement ☐ Withdrawn ☐ New						
C	04		Replacement Withdrawn New						
C	05		Replacement Withdrawn						
C	06		☐ New ☐ Replacement ☐ Withdrawn						
	07		☐ New ☐ Replacement ☐ Withdrawn						
(08		☐ New ☐ Replacement ☐ Withdrawn						
(09		☐ New ☐ Replacement ☐ Withdrawn						
	10		☐ New ☐ Replacement ☐ Withdrawn						

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